

Student/Trainee Information

LAST NAME ☒ _____ FIRST NAME ☒ _____

SS# ☒ _____ DATE OF BIRTH ☒ _____

STREET ADDRESS ☒ _____ APT # ☒ _____

CITY ☒ _____ STATE ☒ _____ ZIP ☒ _____

ROTATION LOCATION ☒ _____ (Ward or service at VA)

BEGIN DATE ☒ _____ COMPLETION DATE ☒ _____

PAY/SALARY/STIPEND ☐ - YES – paid by school ☐ - YES – paid by VA ☒ - NO

SCHOOL ☒ _____

LAST YEAR YOU ANTICIPATE BEING IN A TRAINING PROGRAM AT THIS VA: ☒ _____

HOME EMAIL ADDRESS ☒ _____

DISCIPLINE - Choose discipline best describing your program of study: ☒

- | | | |
|---|---|--|
| <input type="checkbox"/> Audiology & Speech Pathology | <input type="checkbox"/> Medical Laboratory | <input type="checkbox"/> Optometry |
| <input type="checkbox"/> Chaplaincy | <input type="checkbox"/> Medical Student | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Special Fellowship (Ambulatory | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Dietetics | Care, Robert Wood Johnson, etc.) | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Health Information | <input type="checkbox"/> Medical/Surgical Support | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Health Services Research & | (Respiratory Tech, Biomedical | <input type="checkbox"/> Rehabilitation (OT,PT,KT, etc.) |
| Development | Tech, etc.) | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Imaging (Radiologic/Ultrasound | <input type="checkbox"/> Nurse Anesthetist | <input type="checkbox"/> Other, specify _____ |
| Tech, etc.) | <input checked="" type="checkbox"/> Nursing | |

DEGREE LEVEL (for the training program you are currently in) ☒

- | | | |
|--|---|---|
| <input type="checkbox"/> Certificate/Diploma | <input type="checkbox"/> Master's | <input type="checkbox"/> Post-doctoral (other than residents) |
| <input type="checkbox"/> Associate | <input type="checkbox"/> Post-master's fellowship | <input type="checkbox"/> Residency/Fellowship |
| <input type="checkbox"/> Baccalaureate | <input type="checkbox"/> Doctoral | <input type="checkbox"/> Other, specify _____ |

(Initial in the space provided.)

_____ ☒ I understand that I am required to wear my VA ID Badge whenever I am on duty at the VA.

_____ ☒ I understand that I am **STRICTLY PROHIBITED** from disclosing my computer access codes to ANYONE, including my family, friends, fellow workers, supervisor(s), and subordinates, for ANY reason.

_____ ☒ I understand that I must go to the Education Service Line to complete out-processing requirements at the end of my training at the VA. I understand I must surrender my VA ID Badge and parking decal/card. I understand also that my computer access will be withdrawn at the end of my training at the VA.

_____ ☒ I understand that, in the event I continue employment with the VA after my training has been completed, I must coordinate with the Education Service Line to ensure computer access and VA identification is current.

☒ Do you intend to continuing working at this facility after your training is completed? ☐ Yes ☐ No

FOR EDUCATION SERVICE LINE USE ONLY

<input type="checkbox"/> Badge	<input type="checkbox"/> Vehicle Registration	<input type="checkbox"/> Computer Access Required
Cyber Security Training/Date _____	VHA Patient Privacy (HIPAA) Training/Date _____	
Our Turn to Serve Video _____	Logged NPF _____	

All information is for official use only and will be kept confidential.